KANSAS 1915(b) WAIVER PROGRAM

PROJECT NAME:	KANSAS MEDICAID MANAGED CARE PROGRAM
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Superseded by	
1932(a) SPA #02-10 Effective:	**October 1, 2002**
1915(b) Renewal Expiration Date:	October 4, 2002

1932(a) SPA Replaces 1915(b)Waiver: October 1, 2002

PROGRAM SUMMARY

The Kansas Medicaid Managed Care Program consists of a PCCM component "HealthConnect" and a capitated component formerly known as **"**PrimeCare Kansas" operating under a 1915(b) waiver. The name of the capitated component was changed by amendment to "HealthWave." Both components became statewide October 1, 2001. **The 1932(a) SPA #02-10 supersedes #02-04 and replaces the 1915(b) Waiver on October 1, 2002.**

HealthConnect (PCCM)

HealthConnect is a program established by the Kansas Department of Social and Rehabilitation Services (SRS) to allow consumers access to quality medical care. HealthConnect primary care case managers provide medical care to a select group of Medicaid/MediKan beneficiaries or, when necessary, refer the patient to another provider. They can be: Physicians in general practice, family practice, internal medicine, obstetrics and gynecology, or pediatrics; Advanced Registered Nurse Practitioners; Federally Qualified Health Centers; Rural Health Clinics; local health departments; or group practices of the provider types specified above.

HealthConnect was originally approved by HCFA in 1984 under the name Primary Care Network (PCN), and now serves approximately 70,000 Medicaid beneficiaries. It is administered by BlueCross BlueShield of Kansas (BCBS of KS) by contract with the State.

The case manager is paid $2.00 per month for each beneficiary, plus the established fee-for-service allowance for medical services provided. Beneficiaries are restricted to their assigned case manager and may not receive select medical services from other providers without case manager referral. This restriction does not apply to family planning services.

Eligible beneficiaries choose a case manager from the list of enrolled providers. Beneficiaries are not restricted to receive services from their primary care provider or case manager until their blue medical I.D. card specifies a primary care provider.

To be an eligible participant in the HealthConnect program, the following criteria apply:

The beneficiary must fall into one of the following categories of Medicaid eligibility: Temporary Assistance for Needy Families (TANF), Poverty Level Eligible Pregnant Women and Children (PLE), Supplemental Security Income (SSI), or General Assistance (MediKan).

The beneficiary is not a foster/adoption support child, Medicare beneficiary, Qualified Medicare Beneficiary and Medicare eligible, adult care home resident, in a State institution, having Tuberculosis (TB only) coverage, or enrolled in an HMO or other managed care program, or in the Home and Community-Based Services waiver program.

If a provider or health plan (HMO) is not shown on the Medicaid/MediKan I.D. card as the case manager, the beneficiary named on the card is not currently included in managed care, and services may be rendered without referral.

Each case manager may accept up to 1,800 consumers and must accept at least 10 consumers. If a group provider enrolls, the group's maximum number of consumers is equal to the number of eligible case managers in the group multiplied by 1,800. The group may accept a lesser number; however, the minimum caseload of 10 still applies. The provider contract may be canceled at any time by either the case manager or SRS with 60 days written notice.

<u>HealthWave (HW) (Capitated)</u> (formerly PrimeCare Kansas)

The HealthWave program uses a capitated payment model of managed care implemented in December 1995. Beneficiaries in TANF and PLE assistance categories are allowed to choose between HealthWave and HealthConnect.

HealthWave consists of existing HMOs under contract with SRS. SRS makes a monthly payment to an HMO responsible for providing services to beneficiaries as defined in the contract. Services not included in the contract may be billed under fee-for-service guidelines by enrolled Medicaid/Medikan providers. The HMOs are responsible for submitting encounter data

to SRS and reimbursing their network case managers. HMO case managers do not submit claims directly to Medicaid for services they render.

These HMOs are responsible for establishing their own provider networks. HealthWave organizations coordinate and/or subcontract with the following types of providers: Family planning clinics, Federally Qualified Health Centers, Indian Health Centers, local health departments, and Rural Health Clinics. Providers may participate in a HealthWave provider network, if contracted with the HMOs, and the HealthConnect program, as case managers, simultaneously.

The HealthWave program serves approximately 13,000 Medicaid beneficiaries. The Kansas Foundation for Medical Care, the Peer Review Organization for Kansas, performs contract and quality assurance monitoring functions.

HEALTH CARE DELIVERY

Kansas utilizes PCCMs and MCOs to provide all primary care services and necessary specialty services for the Medicaid population. There is one MCO in HealthWave, Horizon Health Plan, which is being purchased by First Guard. Payment methodology to the MCO is an actuarially correct rate under the UPL set by the State for the MCO.

BENEFIT PACKAGE

All Medicaid covered services must be prior approved. Services not covered under the waiver will be provided under fee-for-service.

Excluded Services

Under HealthConnect: Dental, CMHC psychiatry, opthalmology, optometry and eye glasses, obstetrical if the PCCM is not an OB/GYN, pharmacy, podiatry, nursing home and ICF/MR, general transportation and wheelchair van, chiropractic, emergency, behavior management, immunizations, newborn home visits, laboratory and radiology, anesthesia, State institution services, HCBS, assistants at surgery, sexually transmitted disease treatment, prenatal health promotion and risk reduction, and Indian Health Service services.

Under HealthWave: Dental; psychiatry (including psychiatrists, behavior management, CMHC, and partial hospitalizations); pharmacy (Factor 8, mental health only); nursing home and ICF/MR; HCBS abortions; heart, liver, and bone marrow transplants (inpatient services); State mental health institution services; nursing facility for mental health services; head injury rehabilitation facility services; nursing facility services; alcohol and drug abuse except acute medical detoxification; and SRS behavior management.

LOCK-IN PROVISION

Beneficiaries may be locked into their PCCM or MCO for up to one year.

ENROLLMENT BROKER

The State's fiscal agent, BCBS of KS, was the State's enrollment broker, responsible for outreach, education, enrollment, disenrollment, and maintaining a hotline to assist beneficiaries with questions. Beneficiaries may enroll by telephone, by mail, or in person at community presentations. The waiver was amended to allow the state to contract with MAXIMUS as the enrollment broker, replacing BCBS of Kansas.

COST EFFECTIVENESS/FINANCIAL INFORMATION

Kansas anticipates saving approximately $5,893,050 during the current two years of waiver operation. Capitation rates were established on claims incurred in calendar year 1995. The waiver was amended to rebase these capitated rates using more current data.

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